

certain cases of typhoid fever. Long before the evidence of the serum reaction was brought forward it was held by several pathologists that *B. coli* had a share in the causation of typhoid fever. Various observations on the presence of *B. coli* in the spleen and other organs of typhoid patients, and Sanarelli's experiments on the influence of coli toxins in raising the virulence of *B. typhi* had given ground for this conclusion. The study of the regulation of bacterial growth in the intestine which we have just detailed shows, it seems to us, the mode in which normal bacterial processes in the intestine may increase and thereby contribute to a disease without invading the tissues or the blood.

To study this question from another point, we carried out a number of inoculations with races of *B. coli*, in order to compare the reactions developing in consequence in the animal's (rabbit's) blood with those of the blood of a patient in typhoid fever. This method failed, however, to throw much light on the problem we had before us, but this was probably due to the fact that various races of *B. coli* differ very much in their reaction to agglutinating coli serums. It often happens that even when a race which does not easily agglutinate is used for inoculation, the resulting serum will give a reaction with other races of *B. coli* at a dilution much higher than the maximum dilution which will agglutinate the inoculating race. It is consequently impossible to use the serum reaction of the coli group of bacilli in the same definite way as may be permitted with the typhoid group, in which the tendency to agglutinate is much more uniform. There is accordingly an element of uncertainty in interpreting the meaning of coli reaction in a given instance.

Further, in carrying out these inoculations, we tested the rabbit's blood with races of *B. typhi*, and in confirmation of Sternberg's results, we found that the serum had occasionally acquired the power of agglutinating *B. typhi* at a dilution at which it had no effect on the *B. coli* used to inoculate. We do not consider we have yet the data to enable us to interpret this result.

Intracapsular Prostatic Resection. The Normal Method in Cases of Prostatic Hypertrophy.—RYDQIER (*Centralblatt für Chir.*, No. 41, 1902) states that he first recommended enucleation two years ago and that his good results with this method have been equalled by those of Albarran and other surgeons. Further experience with this method has shown that the objection to it is, that no matter whether the enucleation be done with the fingers or with blunt-pointed instruments the prostatic urethra is almost invariably opened. The effect of this is to prolong convalescence, which is undesirable in these cases. For that reason the author now uses the method of intracapsular resection, which avoids this complication by not removing the prostatic tissue lying along the course of the urethra. The technique consists in separating the posterior surface of the prostate from the perineum by a median incision through the raphé. The objection to the half-moon incision between the tuberculi ischii is its danger, and its use can only be recommended in very difficult cases. After splitting the perineal fasciæ the prostate should be exposed by blunt dissection. A catheter of as large a size as possible should have been previously introduced into the urethra. The edges of the wound being held apart, the prostatic capsule should be incised on one side of the median

line, and then held apart with retractors while an attempt is made to pull out the prostate with the fingers. This may be easy at times, at others, when the capsule is thin and adherent to the parenchyma of the gland, it may be a very difficult procedure. The urethra being clearly marked by the catheter, the dissection is stopped before it is reached. Clamps are then applied and the prostatic tissue resected. The operation is usually easy, is not accompanied by much hemorrhage, and can be performed in a short space of time in contradistinction to the Dittel operation which, as Buchhardt has aptly stated, is not technically easy, requires about three hours to perform, and is usually accompanied by much hemorrhage. Only further clinical experience can show as to whether the chances of recurrence are greater after one operation than they are from the other, but the chances at present would seem to be about the same.

Two Cases of Obscure Abdominal Pain; Operations; Results.—PRITCHARD (*British Medical Journal*, December 27, 1902) reports the following cases: Case I., woman, aged fifty-three years, had for twenty-three years been subject to intermittent attacks of acute epigastric pain accompanied by vomiting, and lasting, as a rule, for two or three days. The first attack was characterized by jaundice and the usual symptoms of biliary colic, but no calculus was discovered in the stools. There was no history of any illness except an attack of malarial fever. Three months before the operation the patient noticed that her water became highly colored and the motions pale. Soon afterward she began to feel definitely ill; there was considerable pain in the epigastric region, slightly to the right of the median line, and a temperature of 105° F. This temperature soon became remittent and marked jaundice developed. The patient was better one day and worse the next, and as she was steadily becoming weaker an exploratory laparotomy was finally performed, three months after the date of the beginning of her illness. This was absolutely negative in indicating the cause of her condition. The liver and gall-bladder and, in fact, all the abdominal organs were found to be normal in every way. The temperature became normal after the operation and remained so for eight days, but on the ninth day it rose to 104° F., and again another rise five days later. The skin now began to have the peculiar bronze tinge of Addison's disease, and there were patches of almost completely black pigment on the back of the hands and lower parts of the arms. The scar of the wound was not pigmented. The patient was in a very asthenic condition. Believing in the possibility of disease of the adrenals, small doses of arsenic and strychnine were given, and the patient immediately began to improve and in a few weeks was well enough to go home.

Case II.—Woman, aged fifty-seven years, who complained of pain in the right epigastric region, at the level of the junction of the seventh intercostal cartilage. This pain was intermittent, neuralgic, shooting through to the back, and generally at its severest about three hours after a meal. Diet did not affect the severity of the attacks, which were generally accompanied by flatulency. Any vibration, such as riding in a carriage, increased the pain. Rest in bed and medicines having proven of no benefit, an exploratory laparotomy was performed. This showed a mass of fairly dense, fibrous adhesions